

FILED OCT 13 1947
Registration District No. **287**

Primary Registration District No. **45-12-**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Milan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Hospital - Simpson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community 73 yrs
years, months or days)

3. (a) PRINT FULL NAME John Quincy Boner
3. (b) If veteran, name war 110
3. (c) Social Security No. _____

4. Sex W 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Jane Cassidy 6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased April 13 1874
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 8 If less than one day
hr. _____ min. _____

9. Birthplace Milan Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Boner
13. Birthplace Lawrenceburg Ind
(City, town, or county) (State or foreign country)
14. Maiden name Mary Smith
15. Birthplace Buzzalo N.Y.
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Bird
(b) Address 0 Milan Mo

17. (a) Burial (b) Date thereof 9/24/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakwood

18. (a) Signature of funeral director Schmeier

(b) Address Milan 1110

19. (a) Oct. 4 - 1947 (b) Mrs. H. B. Harris
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State 1110 (b) County Sullivan
(c) City or town Milan
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? 110 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 20
year 1947 hour 3:47 minute 7 P.M.
21. I hereby certify that I attended the deceased from 9-18
1947 to 9-20 1947
that I last saw him alive on 9-20 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage &c.
Due to Senile changes.

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations gym
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature Ed Simpson (M. D. or other) D.O.
Address Milan Date signed 9-21-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 16 1950

RECEIVED
District Health Officer No. 1
District File Number 10-47-138
Date Filed OCT 10 1947

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed..... *Dwight Schauer*

Licensed Embalmer No. *2667*

P. O. Address *Urbana, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.